

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
SPA #03-03

2. STATE
Kansas

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 1, 2003

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 \$ -960,000 780,000 (TAW)
b. FFY 2004 \$ -960,000 780,000 (TAW)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement to Attachment 4.19-A
Page 22

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):
Supplement to Attachment 4.19-A
Page 22

10. SUBJECT OF AMENDMENT:

Methods & Standards for Establishing Payment Rates - Inpatient Hospital Care

11. GOVERNOR'S REVIEW (Check One):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's
Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
// Janet Schalansky - signature //

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Secretary

15. DATE SUBMITTED:

16. RETURN TO:
Janet Schalansky, Secretary
Social & Rehabilitation Services
Docking State Office Building
915 SW Harrison, Room 651S
Topeka, KS 66612-2210

17. DATE RECEIVED

3/21/03

19. EFFECTIVE DATE OF APPROVED MATERIAL

3/1/03

21. TYPED NAME:

CHARLENE BROWN

23. REMARKS

Deputy Director, CHS0

KANSAS MEDICAID STATE PLAN

Attachment 4.19-A

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Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

Section 2.5130 continued

Testing for Day Outlier:

Covered Length of Stay	50 days
Compare With Day Outlier Limit	67 days

Analysis

Cost Outlier: The estimated cost of the claim (\$31,013) is less than the cost outlier limit (\$32,899). Therefore, the claim is not a cost outlier.

Day Outlier: The covered length of stay on the claim (50 days) is less than the day outlier limit (67 days). Therefore, the claim is not a day outlier.

2.5200 Standard DRG Payment

Standard DRG amount will constitute the base payment for an inpatient discharge except in those situations where a partial payment may be made. Any outlier payment for the qualifying claims will be in addition to the standard DRG payment.

Standard DRG amount for a claim can be obtained by multiplying the relative weight of the DRG assigned to the claim, by the group payment rate assigned to the hospital.

Example of Standard DRG Payment Calculation:

Referring to the data in subsection 2.5130:

Standard DRG Payment = DRG Weight x Hospital Group Payment Rate

$$\begin{aligned} &= 4.2294 \times \$ 2,836 \\ &= \$11,995 \end{aligned}$$

2.5300 Payment for Outlier Claims

If a covered general hospital inpatient stay is determined to be a cost or day outlier, the total reimbursement will consist of the standard DRG payment plus an additional amount for the outlier portion of the claim.

2.5310 Cost Outlier Payment

The payment for the cost outlier portion of a claim will be obtained by multiplying the difference between the estimated cost of the claim and the applicable cost outlier limit, by the DRG adjustment percentage. Cost outlier payment will be made for up to 360 inpatient days of stay, beyond which only day outlier payment will be made.

TN# 03-03 Approval Date 5-27-03 Effective Date 3/01/03 Supersedes TN# 02-24